

**Texas Department of Insurance, Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**PART I: GENERAL INFORMATION**

Requestor's Name and Address: NORTHWEST TEXAS HOSPITAL 3255 W PIONEER PKWY ARLINGTON TX 76013	MFDR Tracking #: M4-07-3089-01
Respondent Name and Box #: ASSOC CASUALTY INSURANCE CO. Rep Box # 53	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "We have filed an MDR for this service because we believe that the reimbursement received for this trauma admit (Dx 927.3) was not Fair and Reasonable. Few think that Medicare's reimbursement is Fair and Reasonable, as indicated by the commission's implementation of 140% of Medicare rates for physicians and 213.3% of Medicare rates for free standing surgical centers. The Medicare DRG rate for this service is \$6,229.28 times 140% is \$8,720.99. We only received \$7,745.29 in payment for this service. We request the balance of \$975.70."

Principal Documentation:

1. DWC 60 Package
2. Total Amount Sought - \$975.70
3. Hospital Bill
4. EOBs
5. Medical Records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "The above referenced health care provider is disputing the payment of \$7,745.29 for the hospital's emergency room and subsequent inpatient stay, occurring on 6-26-06 through 6-28-06. NorthWest Texas Hospital billed \$12,315.58 for this admission. The Hospital has filed with Medical Dispute Resolution, requesting an additional reimbursement in the amount of \$975.70."... "In their dispute, NorthWest Texas Hospital has stated, '*Fair and Reasonable is 140% of DRG. DRG is \$6,229.28 X 140% = 8,720.00. Insurance is short 975.70*'. This statement does not meet the definition of a 'position statement' as laid out in Rule 133.307(g)(3)(C)(iii) & (iv). In addition, subsection (g)(3)(D) of this same rule, states 'if the dispute involves treatment(s) and/or service(s) for which the Commission has not established a maximum allowable reimbursement, documentation that discussed, demonstrates, and justified that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with Section 133.1' of the rules should be included by the requestor. No such documentation was included."... "The provider was reimbursed at a fair and reasonable rate as defined by Corvel. 'Trauma' is defined as any ICD-9 code ranging from 800.00 through 959.50 and shall be reimbursed at a fair and reasonable rate for the entire admission. Corvel stands as the original audit was paid correctly, per DWC Acute Care Inpatient Hospital Fee Guideline."

Principal Documentation:

1. DWC 60 Package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
06/26/2006 through 06/28/2006	45, 601, 504, W10	Inpatient Services for Trauma Admission	\$975.70	\$0.00
Total /Due:				\$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code § 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason codes:
 - 45 – Contract/Legislated Fee Arrangement Exceeded.
 - 601 – Non-Physician provider reimbursed @ 75%.
 - 504 – Allowed fee appears reasonable for services.
 - W10 – Payment based on fair & reasonable methodology.
2. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC§134.401(c)(5)(A), effective August 1, 1997, 22 TexReg 6264, which requires that when “Trauma (ICD-9 codes 800.0-959.50)” diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 927.3. The Division therefore determines that this inpatient admission is a trauma admission and shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
3. This dispute relates to outpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 2, 2006, 31 TexReg 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers’ compensation health care network shall be made in accordance with subsection §134.1(d) which states that “Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available.”
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. Division rule at 28 TAC §133.307(e)(2)(A), effective January 1, 2003, 27 TexReg 12282; and applicable to disputes filed on or after January 1, 2003 requires that the request shall include “a copy of all medical bill(s) as originally submitted to the carrier for reconsideration in accordance with §133.304.” This request for medical fee dispute resolution was received by the Division on January 4, 2007. Review of the documentation submitted by the requestor finds that the requestor has not submitted a copy of the original bill. Therefore, the requestor has failed to complete the required sections of the request in the form, format, and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(e)(2)(A).
6. Division rule at 28 TAC §133.307(g)(3)(C), effective January 1, 2003, 27 TexReg 12282; and applicable to disputes filed on or after January 1, 2003 requires the requestor to send additional documentation relevant to the fee dispute including “a statement of the disputed issue(s) that shall include: (i) a description of the healthcare for which payment is in dispute, (ii) the requestor’s reasoning for why the disputed fees should be paid or refunded, (iii) how the Texas Labor Code and commission [now the Division] rules, and fee guidelines, impact the disputed fee issues, and (iv) how the submitted documentation supports the requestor position for each disputed fee issue. Review of the submitted documentation finds that the requestor did not discuss or explain how the Texas Labor Code and Division rules impact the disputed fee issues, or how the submitted documentation supports the requestor’s position for each disputed fee issue. The Division concludes that requestor has not provided documentation sufficient to meet the requirements of Division rule at 28 TAC §133.307(g)(3)(C).
7. Division Rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §133.1 of this title (relating to Definitions) and §134.1 of this title (relating to Use of the Fee Guidelines)”. The requestor asserts in the position statement that “Few think that Medicare’s reimbursement is Fair and Reasonable, as indicated by the commission’s implementation of 140% of Medicare rates for physicians and 213.3% of Medicare rates for free standing surgical centers. The Medicare DRG rate for this service is \$6,229.28 times 140% is \$8,720.99.” The requestor did not list which DRG was used in their position statement to determine the rate. Review of the documentation finds that the requestor did not discuss or explain how it determined that 140% of the Medicare rate would yield a fair and reasonable reimbursement. Nor did the requestor submit evidence to support the proposed methodology. Nor has the requestor discussed how the proposed methodology would be consistent with the criteria of Labor Code §413.011 or 28 TAC §134.1. Additionally, the requestor did not provide documentation, such as Medicare fee schedules, redacted EOBs, payment policy manual excerpts, or other evidence, to support the Medicare payment calculation. Thorough review of the documentation submitted by the requestor finds that the requestor has not discussed, demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. The request for additional reimbursement is not supported.

8. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(e)(2)(A), §133.307(g)(3)(C) and §133.307(g)(3)(G). The Division further concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.307, §134.1, §133.304, §134.401, §133.1
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

12/22/2009

Authorized Signature

Medical Fee Dispute Resolution Officer

Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.